Suicide Prevention Plan Advisory Committee (SPPAC)
Meeting Notes
November 8, 2007
10:00 AM to 5:00 PM
Red Lion Hotel, 1401 Arden Way, Sacramento, CA 95815

Background

On November 8 the California Suicide Prevention Plan Advisory Committee (SPPAC) convened for the fourth time to build upon the information gathered at a series of public workshops and begin setting implementation priorities for specific actions contained in the Plan.

Committee Action Items

- Committee members will review the next iteration of the plan and be ready to discuss it at the final SPPAC meeting.

Discussion Highlights

Committee members generally agreed that certain actions in the Plan were higher priorities than others. The two highest priorities discussed by the group were the establishment of a Statewide Office of Suicide Prevention (OSP) and instituting suicide prevention training requirements for select professions such as primary care physicians. In response to a member question, Ms. Nahat stated that the current plan under discussion is for the Governor to create the OSP by Executive Order in late 2007 or early 2008.

MEETING NOTES

Item I: Introductions, review of the agenda, ground rules & materials

Deb Marois, lead facilitator from the Center for Collaborative Policy, welcomed the committee members. She reviewed the day's agenda, meeting materials, and ground rules. She then invited committee members to introduce themselves.

Item II: Welcome and Updates from the Department of Mental Health (DMH)

Emily Nahat, Prevention and Early Intervention Branch Chief at DMH, welcomed the committee on behalf of the department and introduced several new members and staff including Alice Trujillo from the Department of Drug and Alcohol Programs, Janna Lowder from the Oversight and Accountability Commission (OAC) and Barbara Marquez, Sandra Black, and Michelle Lawson from DMH. Ms. Nahat also announced that DMH staff Beverly Whitcomb recently accepted a position with OAC and thanked

Ms. Whitcomb for her service and contributions to the SPPAC. The goals for the day's meeting were then reviewed, which included:

- Considering the national context of suicide prevention and its implications for California.
- Understanding the outcomes of the public input process.
- Discussing/ recommending priority implementation activities and suggestions for funding priorities.

Ms. Nahat also thanked SPPAC members for taking part in the public workshops in September and reported that over 110 members of the public attended the workshops and provided input on the Plan, including a group of Transition Age Youth (TAY) from Fresno. In addition to the DMH sponsored workshops, Nahat also stated that Dr. Albert Gaw and Tina Yee convened their own meeting in San Francisco with 22 members of the Asian Pacific Islander (API) community to discuss the unique socio-political needs of this community and how they relate to suicide prevention.

Nahat then delivered an update on the status of Plan and the Mental Health Services Act (MHSA). The Plan will have statewide and national implications for suicide prevention efforts, and will serve as another platform to interface with national partners such as the American Association of Suicidology, (AAS) and the Substance Abuse and Mental Health Services Administration (SAMHSA). This interface may create new funding and data sharing opportunities. Key national experts contacted for input on the Plan included:

- Dr. David Litts, Associate Director, National Suicide Prevention Resource Center and Executive Director of the Air Force Suicide Prevention Program.
- Dr. John Draper, Director of the National Suicide Prevention Lifeline and New York City's LifeNet, a central network for federally funded crisis counseling following the 9/11 attack, and former Clinical Director of the New York City Department of Mental Health.
- Dr. Richard McKeon, SAMHSA Suicide Prevention Advisor
- Dr. Jane Pearson, Chair, National Suicide Research Consortium, National Institute of Mental Health and SAMHSA.
- Dr. Lanny Berman, Executive Director of the American Association of Suicidology.

Given the need to incorporate this input to create a complete, well rounded Plan, Nahat reported that the final meeting of the SPPAC has been postponed from November 29 to a date to be determined. The Plan will be reviewed by the OAC at its January meeting.

Given the committee's priority-setting tasks, Nahat asked that members consider the status of other MHSA programs. Specifically, she reported that the Student Mental Health Initiative (SMHI) was approved by the OAC in September and contains $4 million in dedicated suicide prevention funding. An additional $10 million has also been approved for state-administered suicide prevention efforts for a total of $14 million statewide annually for four years. Nahat stated that these programs will:

- Help create a strong foundation in California for a range of suicide prevention activities.
- Provide guidance to the state on suicide prevention community program development.

Discussion:

- A committee member asked if the $14 million will be shared by counties and the state. Ms. Nahat stated that this money will be used primarily for state administered projects. In addition to suicide prevention-specific funding, she also mentioned that counties have access to PEI funding for key at-risk populations, including those at risk for suicide. Examples of these groups include people suffering from early onset of a mental illness and those that have suffered from traumatic experiences.
- Another member asked if state administration costs were built into the $14 million for suicide prevention activities. Ms. Nahat stated that while private contractors for suicide prevention services may draw some administration-related costs from this amount, MHSA dedicates 5 percent of its total funding to DMH administration costs.
- The concern was raised that key goals such as access to lethal means (i.e., gun control) will be extremely difficult to achieve.
- One member commented that suicide prevention funding should not be used for duplicative services or competing programs/entities. Ms. Nahat agreed, and stated that a coordination system at the state level may be needed to avoid such problems.

Item III: Keynote Address by Dr. Lanny Berman, AAS

Dr. Lanny Berman thanked DMH and the SPPAC for the invitation to speak. He then delivered a presentation on the history of national suicide prevention efforts and the need to set clear, *realistic* priorities for future efforts. The full presentation can be found at the following link:
http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/Prior_Meetings.asp

According to Dr. Berman, key elements of a successful suicide prevention plan include:

- A “champion” to create the political will necessary to maintain prevention efforts currently and into the future.
- A reliance on evidence-based practices to provide immediate service to those in need.
- Dedicated funding sources.
- Early detection programs to identify and treat the immediate symptoms and a referral system to provide on-going care.
- Suicide prevention training programs for primary care physicians and other “ground-level” care providers. Dr. Berman commented that even if a person at risk for suicide is identified, care providers lack the training to refer them to the correct services or provide them with the appropriate follow-up care. Often, this

lack of training leads to over prescription of certain medications, particularly anti-depressants.

- To narrow the list of potential suicide indicators to those evidence-based factors considered the most critical, suicide training programs could rely on the IS PATH WARM system, that is:
    - **I** Ideation: threatened or communicated
    - **S** Substance abuse: excessive or increased
    - **P** Purposeless: no reasons for living
    - **A** Anxiety, agitation, or insomnia
    - **T** Trapped: feeling that there is "no way out"
    - **H** Hopelessness
    - **W** Withdrawal from friends and family
    - **A** Anger: uncontrolled rage or seeking revenge
    - **R** Recklessness
    - **M** Mood changes (dramatic)
- Guidelines or mandates for reducing access to lethal means. Dr. Berman stated that the evidence overwhelmingly suggests that reducing access to firearms dramatically reduces suicide rates. Another example of lethal means reduction related to pesticide regulation in Southeast Asia. In some countries, pesticides often used in suicides are now required to be locked up using a two key system so that no one person can access the poison. The result has been a considerable decline in poison-related suicides.
- A holistic approach to suicide: Focusing on one variable of suicide such as depression overlooks a wide range of other symptoms and causes.
- An adaptive management strategy which implies that as more data/ evidence-based practices become available, the Plan will need the flexibility to change.

Discussion:

- A committee member asked if the IS PATH WARM system is designed to recognize suicidal ideation at all ages. Dr. Berman stated that each step in the system applies to all ages and has empirical support.
- Another member asked which states (among those that already have suicide prevention programs) have lethal means reduction programs. Dr. Berman committed to sending this list to the committee as soon as possible.
- Another member asked if there were any examples of successful lethal means reduction programs in the US with a focus on gun control. Dr. Berman stated that in states with stricter gun control laws (e.g., Massachusetts or New York), there are lower rates of firearm-related suicides.
- The concern was raised that survivors of suicide (i.e., those that have lost a family member or friend to suicide) are nine times more likely to complete their own suicide.
- One member asked if Dr. Berman supported a systemic approach to suicide prevention instead of creating focused programs for individual groups. Dr. Berman responded that a successful Plan should *start* with targeted programs to address known problems and run concurrently with long-term strategies such as stigma reduction.

- One member asked Dr. Berman's opinion of the $4 million in suicide prevention funds specifically for the Student Mental Health Initiative. Dr. Berman commented that he was concerned that the money could become homogenized in the broader initiative.
- A member raised the concern that the $11 million for suicide prevention efforts won't be enough to institute a rigorous physician training program and asked what the best use of the funds might be. Dr. Berman stated that leveraging this money against existing programs to secure more support/ funding could be useful.
- The suggestion was raised that the current push for universal health care in California could provide funding for suicide prevention efforts. Dr. Berman stated that if mental health costs are covered in this effort, the suicide rate *will* be significantly reduced.
- When asked where the best place to start setting priorities for suicide prevention should be, Dr. Berman responded that it might not matter as long as there is a sustainable, long term effort.

Ms. Nahat then asked Dr. Berman to provide direction on four key issues including training objectives, depression and its correlation to suicide, competent community programs, and strategic suicide prevention policy making:

- Training objectives: Given the limited funding available, Dr. Berman stated that training mandates or incentives might not cost the state anything. For example, liability insurance providers could offer discounts to trained practitioners.
- Depression: Dr. Berman stated that while depression is a major factor in many suicides, it is not the *only* factor. For every completed suicide involving depression, there are 500 depressed people that don't commit suicide. Most of the time, there are many other factors involved. He also stated that if depression alone were the cause of suicide, antidepressants would have a more significant impact on suicide reduction.
- Competent communities: Dr. Berman commented that counties and local jurisdictions should create forums similar to the SPPAC to discuss and plan prevention activities.
- Strategic policy making: Dr. Berman stressed that no functional policy will pass without a strong suicide prevention champion in the legislature. In some cases, smaller local goals such as a bridge rail may need to be achieved first and used as positive examples for larger issues such as gun control. Public/private partnerships could also be formed to advance policy goals without creating additional bureaucracies.

Item IV: Assessing Initial Priorities for Suicide Prevention

Ms. Marois reviewed the "Worksheet for Identifying Implementation Priorities for Suicide Prevention in California." She instructed SPPAC members to complete the worksheet individually and check any applicable descriptor boxes on the worksheet for each of the Plan's recommended actions. Members also were asked to consider how actions might

be combined for greater impact and what activities need to be implemented first. Ms. Marois also stressed that the exercise should not become a numerical scoring system but instead be used to inform the afternoon discussions and guide members' decisions about implementation priorities.

Item V: Small Group Priority Setting

Upon completion of the individual worksheets, committee members were instructed to form groups of six to discuss their priorities and determine if there existed a common consensus on their three highest priority actions. Members also were asked to discuss when actions should be implemented (short, medium or long-term phases) and which sector(s) could take the lead in implementing the recommendation. Five groups were formed and each completed a final priority-report worksheet. The list below summarizes the results of each group's discussion; each represents consensus within the group unless otherwise indicated:

Team 1:

- Recommended Actions 2.1, 2.2, and 2.3 should be combined to create an OSP that coordinates all state and local suicide prevention efforts.
- Recommended Actions 3.1 and 3.2 should be combined to train key professionals in the health and public service sectors to provide suicide prevention intervention and treatment. State licensing bodies, representatives from high-risk groups and other stakeholders should collaborate to identify the occupations in question and form the requirements.
- Recommended Actions 4.1, 4.2, and 4.3 should be combined to reinforce the idea that no one population is more important than another when developing suicide prevention training. Clients and survivor organizations should be specifically included in developing the core curriculum for these education programs.

Team 2:

- Recommended Actions 2.1 and 2.2 should be combined to create an OSP. Duties of the office would include creating a public outreach campaign, consolidating statewide crisis hotlines and websites into a single consortium, and identifying needed improvements in various laws as they relate to suicide prevention. According to the group, the OSP would create the necessary infrastructure to provide statewide coordination of local efforts and long-term sustainability. The state and counties could lead this effort in the new organization.
- Recommended Actions 1.1 and 1.2 should be combined to enable people to identify family members and friends with mental illness and to recognize the warning signs of suicide. The state and counties would be the leads.
- Recommended Actions 3.2 and 4.1 should be combined to create uniform training requirements for select occupations. According to the group, this would increase the skills of providers and others to accurately diagnose and create effective treatment plans for potentially suicidal individuals. The training

requirements should be coordinated by MHSA Workforce Education and Training (WET) programs and includes schools, colleges, and survivor support systems. This action should be implemented after the establishment of the OSP.

Team 3:

- Recommended Action 3.2 would require suicide prevention training for select professions. The group agreed that this action would be high impact and build upon existing systems (instead of creating new ones). State licensing boards would develop the requirements.
- Recommended Action 4.6 should be implemented as soon as possible to sponsor innovative programs that fill service gaps for at-risk populations. Effective suicide prevention programs already in place (private or public) should be replicated whenever possible. Three of six group members agreed that this was the highest priority, although all group members indicated this was very important.
- Recommended Action 4.3 should be implemented immediately to integrate suicide prevention programs into community-based older adult programs, with the California Department of Aging (CDA) as the lead. Suicide prevention training should also be required for meals-on-wheels workers.
- Recommended Action 2.3 should be implemented to create a statewide consortium of 24 hour crisis lines and websites.

Team 4:

- Recommended Actions 3.1 and 3.2 should be combined to require training for selected occupations with special emphasis on UC Medical Schools. Training standards and requirement should be implemented as soon as possible. The state and UC would provide leadership for this action.
- Recommended Action 4.1 should be implemented in a "second phase" to provide suicide prevention education in schools. The state should provide leadership.
- Recommended Action 4.3 should also be implemented in a "second phase" to provide suicide prevention programs to elderly groups with an emphasis on grassroots organizations. The state should partner with private foundations to provide leadership for this action.

Team 5:

- Recommended Actions 2.1, 2.2, and 2.5 should be combined to form a Statewide Office of Suicide Prevention (OSP) that appoints liaisons to the corresponding agency in each county. Suicide review teams and "policy action teams" should also be established at the county level. According to the group, this action would provide a good place to start and create the necessary infrastructure to implement plan activities.
- Recommended Actions 3.2 and 3.4 should be combined to require suicide prevention training for select occupations. This would provide the necessary education to identify and treat individuals in crisis as early as possible. Additionally, in organizations such as schools and community groups, trained professionals could provide a "roadmap" that links individuals with the necessary

services. This action would be led by state and county regulatory/ licensing boards.

- Recommended Actions 4.1 and 1.2 should be combined to integrate suicide prevention and early integration programs into K-12/higher education institutions. Such programs would provide a broad approach to education, identify at-risk individuals, and reduce stigma. This action would be led by state and county educational institutions.

Item VI: Large Group Priority Setting

After discussing their priorities in a small group setting, committee members were asked to share their findings with the larger group. Facilitators Marois and Susan Sherry recorded the individual group findings and consolidated the small group priorities into the following set of SPPAC priorities including:

1) The State Office of Suicide Prevention (OSP), local coordination, and suicide review teams (RA 2.1, 2.2 and 5.2).
    a) Highest priority action. The office must be established before other programs can be put in place.
    b) Organized
    c) Priority tasks
    d) Incorporate fund development into work of office (think like a nonprofit)
    e) Leverage existing resources
    f) Offer web based resources and link to peer resources
    g) Link to data collection and public awareness campaign

2) Training to identify and treat/provide roadmaps for local services (RA 3.2 and 3.4)
    a) These standards should be developed in concert with the OSP.
    b) Begin with providers/licensed professionals
    c) Coordinate with MHSA education and training component
    d) Partner with the UC Medical system (MIND institute, COPS)
    e) Customize for local areas, provide them with the roadmap of local services
    f) Work with providers of CEU's, link to licensure requirements, may require mandate
    g) Emphasis on high risk

3) Education about suicide prevention in K-12 and higher education (RA 4.1)
    a) Implement after training standards that are already in place
    b) Suicide prevention programs should be approached from a public-health perspective similar to the anti-smoking campaign
    c) Encourage private schools to take part in suicide prevention programs.
    d) Focus on young adults at high risk and those who may not be in traditional educational settings (e.g., foster youth, juvenile detention)

4) A focus on older adults as high-risk population (RA 4.3)
    a) Use evidence-based, successful practices and partner with private foundations already training care providers.
    b) Use the existing infrastructure via CDA and the Area Agencies on Aging (AAA).

5) Support/sustain culturally competent, innovative programs that fill service gaps (RA 4.6)
    a) Create a set-aside for grass-roots programs to capture unique, innovative, creative activities that could be replicated.
    b) Cultural competence embedded in all actions as a guiding principle

6) A public awareness campaign (RA 1.1)
    a) Link to state Office of Suicide Prevention
    b) Link to education systems, begin the campaign there

7) Successful community programs for at-risk populations should be replicated wherever possible.

After discussing the Plan priorities, Ms. Marois asked the committee to think about priorities for suicide prevention activities specifically funded under MHSA. Ms. Nahat distributed a handout of current funding dedicated to suicide prevention and listed the costs of several projects similar to potential suicide prevention activities including:

- Past mass media campaigns have cost a minimum of $10 million per year. It is assumed that this amount would be needed to produce a similar, sustained effort for a suicide prevention campaign.
- Statewide helplines. DMH estimates that enhancing help/crisis lines would cost approximately $1.5 million per year.
- A training-of-trainers program would cost $2 million per year.
- A single data collection and research project would cost $700,000 per year.
- A learning collaborative could be funded for $750,000 per year.

Committee members were then asked to consider these potential costs and individually write their top MHSA *funding* priorities in relation to the programmatic, planning, and policy priorities already discussed. Follow-up analysis of the written submissions resulted in four common funding priorities including:

1) Creating suicide prevention campaigns in schools, including K-12 and higher education institutions. Six committee members believed this was the highest MHSA funding priority.
2) Creating a public awareness campaign to inform the community about risk factors related to suicide and stigma reduction. Four members listed this as a high MHSA funding priority.
3) Training requirements and licensing requirements for all health facilities (hospitals, group homes, nursing homes, etc.). Three members listed this as a high MHSA funding priority.

4) Creating suicide prevention programs tailored to the needs of older adults. Three members listed this as a high MHSA funding priority.

Other issues/ priorities listed as considerations for MHSA suicide prevention funding included:

- Communication modalities with the deaf community
- Provide the Plan in alternate formats
- Create a comprehensive resource list of peer run/ client run organizations
- Create a clear message from the Governor to all county health commissioners to highlight the priorities of suicide prevention to demonstrate "political will."
- Solicit demonstration projects for SPPAC identified priorities.
- Integrate PEI activities in all K-12 schools.
- Fund peer support programs (hotlines, acute consumer support groups, etc.)
- Expand MHSA suicide prevention funding by leveraging the California Department of Aging. Take advantage of existing non-profit organizations that routinely come in contact with elderly populations such as Meals on Wheels.
- Learning collaboratives.
- Activities that contribute to service coordination at the state and local level. Highlight best practices and disseminate this information
- The roadmap of services is critical at the state and county level.
- Use funds to develop grass roots, community-based programs on suicide prevention programs for schools and the elderly.
- Create statewide consortium of 24-hour suicide prevention hotlines
- Create Office of Suicide Prevention at the state and local levels.

One member asked if DMH has a mechanism to evaluate county achievements with MHSA funding. Ms. Nahat stated that DMH has some evaluation elements in place for Community Services and Supports, an evaluation framework for PEI, and other elements under development.

Item VII: Plan Review

Ms. Nahat reviewed the "Summary of Public Comment" and stated that there was significant overlap between comments made during the public workshops, such as the need for cultural competence. It was decided that cultural competence and other pervasive values should be included in a set of "guiding principles" for the Plan. This will avoid repetition and help make the document more concise. Ms. Nahat distributed the document "Guiding Principles for the CA Strategic Plan on Suicide Prevention, Discussion Draft 11-8-07" and requested that members provide feedback off-line.

Prior to the meeting, SPPAC members submitted remaining Plan items that require discussion before the committee concludes its work. Three issues were submitted:

- Mandating suicide crisis lines in all counties, similar to the current child-abuse reporting system. The crisis lines should be operated to comply with SAMHSA guidelines for the National Suicide Prevention Lifeline.

- Screening for the potential suicidality of students in schools should be included in Strategic Direction 4 of the Plan. This screening could be based on evidence-based approaches such as Columbia Teen Screen already active in some California school districts.
- Identifying survivors (that is family members and friends of someone who has completed a suicide) as an at-risk group in Strategic Direction 4. Current evidence suggests that survivors of suicide loss are 9 times more likely to take their own life.

Ms. Marois briefly summarized each issue and asked committee members to add clarification as needed. Members then discussed reasons to support and causes for concern with each issue.

SPPAC members discussed mandated county crisis hotlines in some detail. Because suicide prevention is not a mandated service per se, programs are often cut or reduced when there are funding shortages. While large counties have the capacity to fund their own systems, smaller counties do not. Crisis calls are sometimes routed to out-of-state hotlines where clients may not be referred to local resources. It was generally agreed that mandated hotlines would be a good idea and help focus attention on the issue. Three concerns were raised:

- A required hotline could overlook non-English users. However, one member pointed out that the two national hotlines must have interpretation contractors available if they do not have someone on staff that can speak key languages.
- Mental health clients should be included in any discussion of state mandated local hotlines.
- It may not be economically feasible to fund a crisis hotline in each county. One member suggested that rural counties could collaborate to offer hotlines to reduce costs.

The members also discussed screening measures in K-12 education. A significant concern arose that school-wide suicide screening could lead to involuntary services and/or stigma and discrimination. No decision or agreement was reached on this topic. There were no objections or concerns raised regarding including survivors of suicide loss as a high-risk group.

Item VIII: Wrap Up, Evaluation and Homework

Committee members completed meeting evaluations. Committee members will receive the next iteration of the Plan for a final review prior to the last SPPAC meeting. DMH will notify members of the new meeting date as soon as possible.

Adjournment: 5:00 pm

ATTENDEES

Committee members

Last	First	Affiliation
Areán, Ph.D.	Patricia	University of California, San Francisco
Bateson	John	Contra Costa Crisis Center
Bell, Ph.D.	Susan	University of California, Berkeley
Bloom	Sam	SPAN-California
Boomer	Lisle	Protection and Advocacy, Inc.
Bragg	Martin	CA Polytechnic State University, San Luis Obispo
Brody	Delphine	California Network of Mental Health Clients
Buck	John	Turning Point Community Programs
Cawthorn, M.F.T., M.A.C.	Rick	Hoopa Valley Tribal Council
Colwell	Barbara	LA Unified School District
Cory	Carole	California Department of Aging
Curren	Joe	Redwood Coast Senior, Inc.
Curry, Ph.D.	Kita	CCCMHA & Didi Hirsch Community Mental Health Center
Garcia	Luis	California Mental Health Planning Council
Gaw, M.D., D.L.F.A.P.A	Albert	SF DPH CMHS (Community Mental Health Services)
Gorewitz, Ph.D.	Janet	Martinez Detention Facility
Gouveia	Leann	Fresno Survivors of Suicide Loss
Lowder	Janna	MHSA Oversight and Accountability Commission
Peña	Maria	Mira Costa College Disabled Student Programs and Services
Pines, Ph.D.	Michael	LA County Office of Education (ret)
Ranahan	Dede	National Alliance of Mental Illness, California
Robbins, C.F.R.E.	Charles	The Trevor Project, Administrative Offices
Sheldon	Betsy	California Department of Education
Trent, Ph.D.	Roger	California Department of Health Services, Epidemiology & Prevention for Injury Control (EPIC) Branch
Trujillo	Alice	Department of Drug and Alcohol Programs
Willson	Billee	Sacramento County Department of Health and Human Services
Yee, Ph.D.	Tina Tong	SF Community Behavioral Services

Project Staff

DMH: Emily Nahat, Barbara Marquez, Orlando Fuentes, Sandra Black, Diane Stidger

CSUS Center for Collaborative Policy: Deb Marois, Susan Sherry, Sam Magill,

Consultant/Writer: Sharleen Dolan

DOCUMENTS AVAILABLE

- Agenda
- Biography for Alan L. “Lanny” Berman
- Suicide Prevention: A National and State Imperative, PowerPoint presentation
- MHSA PEI *Stigma and Discrimination Report Fact Sheet*
- MHSA PEI *Student Mental Health Initiative (SMHI) Fact Sheet*
- California Strategic Plan on Suicide Prevention
- Notes from August 9th SPPAC meeting
- SPPAC Initial Priorities Identified August 9th
- Worksheet for Identifying Implementation Priorities for Suicide Prevention in California
- Identifying Priorities Worksheet Definitions
- Guiding Principles for the CA Strategic Plan on Suicide Prevention, Discussion Draft 11-8-07
- Summary of Public Comments from Regional Workshops and Comment Period ending September 30, 2007